Spirituality and Mental Health

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2 August 2019

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Abstract

In many contexts, emotional ailments have been considered problems of religious or spiritual origin. Historically, religious groups were often the primary providers of mental health care. This changed over time with advances in medicine and Freud's writings framing religion/spirituality (R/S) as a sign of neurosis. In the early- to mid-twentieth century, mental health and R/S were often viewed by Western clinicians and patients as separate and antithetical. Recent decades have been marked by another shift in thought, with increased interest in the overlap between mental health and R/S, and recognition that R/S may in fact serve protective and healing roles in the face of emotional suffering. There has been a concomitant increase in research investigating the connections between R/S and mental health, along with increased development and application of clinical interventions addressing the two in combination. In this narrative review we summarize the history of how mental health and R/S have been viewed as relating to one another, recent research evidence on the effects of R/S on mental health, and clinical implications of these findings. We conclude with a discussion of ongoing challenges and opportunities in the study and application of how mental health and R/S affect one another.

Key Words: Religion, spirituality, mental health, spiritual history, spiritually-integrated treatment

Introduction

Given the high proportion of the world's population that values R/S, and the significant morbidity and mortality associated with mental illness, recent decades have been marked by increased interest in connections between the two fields. In this narrative review we provide an overview of historical connections between mental health and R/S, along with a summary of recent research, clinical implications, challenges and opportunities for future study.

Definitions

Recognizing that spirituality and religion are difficult to define, in this review we use the definition of spirituality proposed by Cook: 'Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the subjective awareness of individuals and within communities, social groups, and traditions. It may be experienced as a relationship with that which is intimately "inner," immanent and personal, within the self and others, and/or as relationship with that which is wholly "other," transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values' (Cook 2004).

The overlap and distinctions between religion and spirituality are complex. Religion generally refers to a tradition of beliefs, experiences and practices that are related to the sacred, common among a group of people, and capable of being experienced individually, institutionally, and/or socially. For many individuals, religion is intertwined with spirituality. For others, the two are

separate. For example, many individuals identify as spiritual but not religious (King et al. 2013). In research, religion is often studied by measuring aspects of religiosity such as religious service attendance, community involvement, or affiliation. These factors are typically more concrete, measurable, and constant than spirituality, and less subject to confounding when examining connections with mental health (Koenig 2008). Given the distinctions between religion and spirituality, research findings on religion may not extrapolate to spirituality.

Historical perspectives

Historically, mental health struggles were viewed as primarily R/S problems. In early antiquity, some saw mental illness as a gift that enabled shamans to communicate with the spiritual world to heal physical illness. In other belief systems, including Christianity and Judaism during the Middle Ages, mental illness was at times considered the result of demonic possession, leading to persecution of suffering individuals. Alongside these beliefs, however, religious groups were often the primary purveyors of mental health care. Across Islam, Christianity, and Judaism, religious groups established many of the early hospitals caring for the mentally ill. Complementing typical hospital care, addressing mental suffering often included prayer, blessings, and reading holy texts (Koenig 2005).

Beginning in the European Age of Reason in the seventeenth century, mental health was viewed more medically. As the scientific method emerged, tension grew between scientific and spiritual understandings of illness. A sharp schism between mental health and religion in Western cultures occurred in the early twentieth century when prominent neurologist Sigmund Freud publicly

denounced religion as pathological, referring to religion as 'the universal obsessional neurosis of humanity,' consisting of 'wishful illusions together with a disavowal of reality' (1962). Though medicine was becoming more evidence-based, a review by Sanua (1969) concluded that there was no evidence that R/S was beneficial to well-being.[2]

The above statements and findings colored the public's views throughout much of the twentieth century. Surveys in the late twentieth century revealed that mental health professionals were less religious than the general population, a phenomenon called the religiosity gap (Cook 2011; Neeleman and King 1993). In psychiatry journals, discussing religion as a factor in mental health was rare (Weaver et al. 1998). Many religious groups considered secular mental health concepts antithetical to holy texts and beliefs, and discouraged believers from seeking mental health treatment (Pargament and Lomax 2013). The idea that psychotherapists could offer to integrate patient R/S into therapy was generally seen as inappropriate (Helminiak 2001). Training for mental health professionals regarding R/S was rare (Sansone, Khatain, and Rodenhauser 1990).

The past several decades have seen the development of a new era, marked by increasing interest in connections between R/S and mental health. Mental health treatments involving spiritual concepts, such as Alcoholics Anonymous or mindfulness/meditation, have become widely accepted (Galanter, Dermatis, and Sampson 2014; Ludwig and Kabat-Zinn 2008). Professional organizations including the American Psychiatric Association (APA) (1990), Royal College of Psychiatrists (Cook 2013b), and World Psychiatric Association (Moreira-Almeida et al. 2016)

[2] The history detailed in the first two paragraphs of this section was drawn primarily from the account provided in Harold Koenig's book *Faith & Mental Health: Religious Resources for Healing*.

have published formal statements on the importance of R/S in psychiatry. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, published in 2013, includes the Cultural Formulation Interview, which guides clinicians to attend to various aspects of patient culture, including R/S (Lewis-Fernandez et al. 2015).

Both contributing to and resulting from this shift in thought over recent decades, there is now a plethora of data on how R/S and mental health relate to one another. In the following sections we summarize key findings from recent research, along with potential clinical applications and areas for future study.

Current evidence

Is R/S associated with mental health?

In contrast to Sanua's conclusion in 1969 that there was no evidence for R/S benefiting well-being, a review of studies of religious commitment in two psychiatry journals from 1978-1989 revealed that 72% of studies reported a positive association between R/S and mental health, while only 16% showed a significant negative association (Larson et al. 1992). Since then, the amount of relevant literature has drastically increased. By 2001 there had been 1300 studies published examining R/S and health (not limited to mental health); by 2010, this number had risen to over 3000 (Koenig, King, and Carson 2012).

What did these studies show? In the second edition of the *Handbook of Religion and Health* published in 2012, Koenig reviewed 3300 studies from 1932 to 2010 on religion and health(Koenig, King, and Carson 2012). In studies of R/S and depression, 61% of 444 studies showed an inverse relationship between R/S and depression. The same was found for 75% of studies on R/S and suicide, 49% of studies on R/S and anxiety, 86% of studies on R/S and alcohol use, and 84% of studies on R/S and general substance use. When selecting for higher-quality studies, these proportions increased in every category. A summary of these findings can be found in Koenig's recent update (2015).

More recently, various studies have been published analyzing larger data sets, continuing to show positive relationships between R/S and mental health. An analysis of a subsample of 17,727 adolescents in the US National Survey on Drug Use and Health showed that adolescent religiosity was inversely related to depression. After controlling for depression and for respondents' and peers' attitudes on substance use, religiosity remained inversely correlated with measures of substance use (Ford and Hill 2012). An analysis of data from the National Health and Nutrition Examination Survey (NHANES-III) found that among nearly 90,000 women aged 30-55, attending religious services at least once per week was associated with an approximately 5-fold lower rate of suicide compared with never attending religious services (VanderWeele et al. 2016). While these findings show correlation rather than causality, they challenge the earlier anecdotal statements that R/S contributes to mental illness.

How is R/S helpful to mental health?

Given this correlation between R/S and mental health, there is question of whether R/S involvement is a marker or result of better mental health, or whether R/S may act in a preventive or therapeutic manner. The cross-sectional design of many studies makes causality difficult to determine. Heterogeneity in definitions of R/S has also been limiting. In some instances, spirituality is measured or defined related to other markers of psychological wellbeing such as hope or optimism, confounding results (Dein, Cook, and Koenig 2012). As such, how R/S and mental health affect one another remains an area of ongoing study. Here we summarize a few proposed mechanisms.

1.) *Social factors:* In Durkheim's 1897 publication *On Suicide*, the author observed lower suicide rates in Catholic regions than Protestant regions of Europe, and attributed this to the social cohesion associated with Catholicism (Durkheim 2006). Although the ecological methods of this study have been criticized, various studies have since shown, with improved methods, that social aspects of religious involvement can buffer against mental illness, especially depression. Though it is difficult to remove confounders, social aspects of religious involvement appear to improve mental health directly as well as indirectly, through health behaviors affecting other medical conditions (Chatters et al. 2015; Hovey et al. 2014; Morton, Lee, and Martin 2017).

2.) *Relational spirituality*: This term refers here to the manner in which one relates to the sacred (Sandage and Schults 2007). An individual's relationship to a higher power may mediate the effects of spirituality on mental health. For example, a view of God as harsh or punishing could contribute to worsening depressive behaviors or beliefs, whereas a

view of a higher power who loves unconditionally could provide a corrective emotional experience following a traumatic childhood. One's attachment style can help predict whether relational spirituality will be helpful or harmful. In a study of 1511 adults from the Baylor Religion Survey, prayer was associated with fewer anxiety symptoms for those with a secure attachment to God, with the opposite correlation present for those with insecure attachment (Ellison et al. 2014). Similar findings have been described by other authors for anxiety as well as depression, and may help to explain why R/S correlates with better mental health for only a subgroup of patients (Paine and Sandage 2017; Rowatt and Kirkpatrick 2002).

The importance of relational spirituality can also be seen through the power of transcendent encounters in promoting recovery from mental illness. This has been observed in individuals in 12-step programs who describe spiritual awakenings aiding sobriety (Kaskutas, Bond, and Weisner 2003). Another famous testimony is that of psychologist Marsha Linehan experiencing a transformative spiritual moment amidst her struggle with borderline personality disorder. She describes how through prayer she grasped the concept of radical acceptance, enabling her to cope with her illness (Carey 2011).

3.) *Moral beliefs:* Many world religions prohibit suicide to some extent (Gearing and Lizardi 2009), and moral objection to suicide is associated with lower likelihood of suicidal behavior (Lizardi et al. 2008). Similarly, prohibition of substance use likely helps explain the association between religious activity and diminished substance use (Morton, Lee,

and Martin 2017). In an analysis of data from the Nurses' Health Study, there was evidence that social integration, depressive symptoms, and alcohol consumption partially mediated the inverse relationship between religious service attendance and suicide, but only for those who attended services occasionally rather than frequently. The finding that these factors did not mediate the relationship between service attendance and suicide for those who attended services frequently, suggests that moral beliefs may be a dominant mediating pathway for those with high levels of religious involvement (VanderWeele et al. 2016)..

Religion/spirituality is also hypothesized to impact mental wellness by nurturing qualities such as gratitude, forgiveness, and humility. These and similar virtues are encouraged by a variety of R/S groups (Olson, Knepple Carney, and Hicks Patrick 2018; Peteet 2014), and are called transcendent virtues due to their power to draw individuals beyond themselves. Transcendent virtues correlate with improved mental health, and beyond correlation may explain some of the interplay between R/S and wellness (Krause 2018; Sapmaz et al. 2016).

4.) *Spiritual practices*: Many studies have noted the potential of the Buddhist practice of meditation to diminish the incidence and burden of mental illness. These include neuroimaging studies showing differences in cerebral blood flow between individuals who regularly meditate compared to those who do not, with marked differences shown in brain areas mediating attention and emotion (Newberg et al. 2010; Sampaio, Lima, and Ladeia 2017). Prayer practices across other religions have similarities to Buddhist

meditation, including a focus on peacefully contemplating the sacred. While one would expect these practices to similarly aid mental health, and this has been suggested by some studies, more research is needed (Ijaz, Khalily, and Ahmad 2017; Larrivee and Echarte 2018).

5.) *Neurobiological factors:* Recent years have been marked by an increased examination of neurobiology in R/S and mental health. One significant finding relates to cerebral cortical thickness. Psychiatric epidemiologists examining participants with high familial risk of depression have observed a relationship between R/S and cortical thickness. While individuals at high risk of depression showed increased cortical thinning, this thinning was significantly less for those who reported R/S as very important, suggesting protection via cortical reserve (Miller et al. 2014). The mechanism of attenuated cortical thinning is currently unclear. While this neuroanatomic finding could be a reflection of other mediating factors between R/S and health listed above, it is also possible that attenuated cortical thinning preceded and/or contributed to these individuals valuing R/S highly.

How is R/S harmful to mental health?

A significant minority of studies show a negative association between R/S and mental health. The discussion above on relational spirituality shows how R/S may be experienced as helpful only to certain individuals. It has also been suggested that high standards of behavior advocated by R/S communities, and abuses within communities, may enhance guilt and shame, contributing to depression and anxiety. In cults or extreme religious movements, spirituality can be overtly

pathological. A cult is defined as a group or movement where members have a common, excessive dedication to a person or idea. Additional features include members being controlled, exploited, and made dependent on the group, leading to psychological harm. Individuals who leave cults commonly experience phobias, depression, and trauma-related symptoms. It is suggested that any R/S group exists on a continuum from healthy R/S to the more controlling, harmful nature of a cult. Factors that move a group along the spectrum toward harmful spirituality include rigidity of belief, coercion, discouragement of members asking questions, approval of members being strictly conditional, and alienation of members from outside supports. The presence of these factors likely contributes to R/S being associated with worse mental health in certain cases (Crowley and Jenkinson 2009).

Another area of study pertains to R/S struggles. These are tensions, conflicts, or strains about sacred matters within oneself, with others, and with the supernatural (Pargament et al. 2005). Religious struggles can be primary (contributing to psychological suffering), secondary (resulting from psychopathology), or complex (a combination of primary and secondary), and are associated with poorer mental and physical health (McConnell et al. 2006; Pargament et al. 2001). Other studies refer to negative religious coping, a synonym for religious struggle. Negative religious coping relates to spiritual discontent or negative appraisals of religious content, in contrast to positive coping which involves mobilization of supports and reliance on hope from one's beliefs. These differences in interpreting and responding to R/S content may explain the presence of negative correlations between R/S and mental health.

Clinical implications

Given the research on religion impacting mental health, there is a growing consensus from academic societies and the Joint Commission (2011) that clinicians should inquire about patients' R/S and how patients may want R/S involved in care (Moreira-Almeida, Koenig, and Lucchetti 2014; Puchalski and Romer 2000). These recommendations are based on studies showing that many patients prefer for clinicians to ask about R/S (D'Souza 2002; Egan et al. 2018; Stanley 2011), and that taking a spiritual history can be associated with enhanced trust in physicians (Ehman et al. 1999), improved treatment adherence (Huguelet et al. 2011; Koenig, King, and Carson 2012), and therapeutic benefit from the interview itself (Goncalves et al. 2016; Kristeller et al. 2005). There are multiple tools and recommendations on how to take a spiritual history, discussed in detail elsewhere (Culliford 2007; Lucchetti, Bassi, and Lucchetti 2013; Moreira-Almeida, Koenig, and Lucchetti 2014).

In addition to asking patients about R/S, clinicians should become familiar with how to integrate patient R/S into care. This involves first asking each patient how he would like R/S involved in his treatment. If a patient wants specific spiritual guidance outside the clinician's expertise, the clinician should refer the patient to community R/S resources to supplement traditional mental health care. In other situations, the patient may be best served by spiritually-integrated psychotherapy. This term refers to therapy provided by a mental health specialist with intentional, overt emphasis on including the patient's world view in treatment. This can include eclectic or psychodynamic therapies as well as CBTs, with recent development of a multiple religion-specific CBTs for Christianity, Judaism, Islam, Hinduism, and Buddhism (Pearce et al.

2015). A recent meta-analysis showed that spiritually-integrated psychotherapy is at least as effective as secular psychotherapy (Worthington et al. 2011).

Each of these applications brings up ethical and boundary issues. Can one discourage participation in a religious community that appears harmful? What should a clinician share if the patient asks about the clinician's beliefs? Close attention to these issues and consultation with colleagues is encouraged. Consideration of one's own views can help clinicians to anticipate and manage countertransference. While further research and consensus is needed regarding ethical and boundary issues, it is clear that clinicians must be very aware of both the boundaries between their patients and themselves, along with the limits of their own training (Peteet, Dell, and Fung 2018).

Challenges and opportunities

Despite the progress that has been made in understanding and integrating R/S and mental health, challenges remain. Most studies show correlation rather than causation, leaving the mechanisms by which R/S affects mental health (and vice-versa) still to be determined. Whereas the past several decades have been marked by an increase in relevant literature, there is now need for an increase in high quality literature to answer more specific research questions.

While this review has focused mainly on studies of individuals participating in major world religions, fewer studies have examined patients who identify as atheist, members of less mainstream religions, or spiritual but not religious. The latter group constitutes a large

proportion of the population and is an interesting group for future study. A cross-sectional study of 7403 individuals in the United Kingdom revealed that those who identified as spiritual but not religious were more likely than those in other groups to have used substances, have a substance use disorder, suffer from an anxiety disorder, and take psychiatric medications (King et al. 2013). A prospective cohort study of 8318 individuals across seven countries showed that individuals who identified as spiritual rather than religious were nearly three times more likely to have a depressive episode when compared to the secular group (Leurent et al. 2013). These findings suggest that individuals who are spiritual in the absence of established religion may have elevated vulnerability to mental illness; mechanisms and implications of this finding are unclear at this time.

Similar to the need for more research on R/S and mental health, progress is needed in clinical applications. Most physicians report having never addressed R/S in practice (Lucchetti et al. 2011), and patients continue to have undetected R/S needs (Austin et al. 2016; Clark, Drain, and Malone 2003). Commonly cited barriers to taking a spiritual history include lack of formal training, (Koenig et al. 2010), lack of time, discomfort with the topic, and fear of imposing R/S views on patients (Koenig 2002). While many would consider increased focus on R/S by mental health clinicians a goal, the topic is controversial. Sloan notes that data on R/S and mental health is often interpreted in a reductionist and even blasphemous manner, arguing that the spiritual history can be unnecessarily intrusive and counterproductive to care (Sloan, Bagiella, and Powell 1999; Sloan et al. 2000). Others have similarly noted the potential for clinicians to proselytize, overshare, or move beyond their area of expertise. Cook summarizes this controversy and notes

that this debate is likely to help the field of R/S and mental health to mature by clarifying both interpretations of research and guidelines for clinical practice (Cook 2013a).

Finally, stigma reinforced by religious groups continues to constitute a barrier to mental health care. In a 2007 study of 293 mentally ill individuals who identified as Christian, just under a third of the participants who sought counsel from the church reported that they had been met with negative reactions, blaming them for their own symptoms or leading them to be no longer welcome in the church community (Stanford 2007). Due to these types of reactions, individuals may keep their symptoms private, forgoing needed care. One proposed way to address this issue is for clinicians to collaborate with faith groups and leaders. The APA's Mental Health and Faith Community Partnership (APA 2019) provides various resources for such outreach. While responses to mental illness have been less studied outside of Christianity, stigma has also been observed in other religious groups (Ciftci, Jones, and Corrigan 2013). There is a need for further study of how R/S groups perceive and react to mental illness, how this affects access to and outcomes of care, and what interventions may help alleviate stigma.

Conclusion

Increased interest in the overlap between R/S and mental health over recent decades has prompted growth in both research and clinical domains. This brief narrative review summarizes these recent developments. More nuanced, high-quality research will help to inform further clinical and community interventions to enhance patient care.

Acknowledgements: None

Declaration of interest statement: The authors have no financial disclosures relevant to this manuscript.

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